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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Mammary Tumours. By GEORGE BUCHANAN, M.D., Prof. Clin. Surgery in the University of Glasgow.

GENTLEMEN: I propose to bring before you to-day some cases that have happened at different times during the previous few weeks, and of which we have another example to-day. I refer to cases of tumour of the mamma. Before introducing the patient, the history of whose case will form the text of our lecture, I have to remind you that the study of tumours, and especially of malignant tumours, may be viewed in three aspects. First, in your systematic lectures on surgery, you get a complete view of the whole subject of tumours, without reference to particular examples. Secondly, in your class of pathology, you study and have demonstrated to you the origin, growth, and internal structure of these tumours. The

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object of a clinical explanation of these subjects is to concentrate into a focus just as much of all that scattered information as really avails you in practice. It is exceedingly interesting philosophically to study what are the causes, proximate and remote, the mode of growth, the internal structure, and the progress of these things; but when you have to deal with a living person, only a certain amount of that great extent of information really comes into play. I wish, if possible, to concentrate into these remarks the most of what is available, supposing you in private have to deal with a case such as that now brought in.

This woman is forty years of age, unmarried, of spare habit of body; and hitherto she has enjoyed good health. The catamenial function was regular from its appearance up till eighteen months ago, since which time it has altogether ceased, without any cause. Three months ago, she became aware of a tumour in her right mamma. Her attention was drawn to it by feeling her dress a little tight. There was no pain when she discovered it. During the last three months, it has increased in size, and the growth has been more rapid of late, especially during the last two weeks, following on a slight blow on the back of a chair; though, remember, I do not say that was the cause. In the right mamma, occupying the upper portion, there is a tumour which is irregular, nodular, about four inches in diameter, and to the feel about three inches thick. The tumour and the gland in which it is imbedded move freely upon the subjacent structures, and are not in any way adherent. Immediately above the nipple, the skin is partially adherent to the tumour; but towards the circumference it is freely movable upon it. The nipple is slightly retracted, but not to any extreme degree. The axillary glands are perfectly free from implication. So far as the patient's sensation is concerned, there is no difference between the two mammæ, except what is produced by the weight of the tumour on the right side. I may say negatively that there is no shooting or burning pain. The tumour is, as I have said, slightly irregular in form, and hard to the feel.

Such is the case, and a very valuable case it is to learn from; because, although I have no doubt in my own mind as to the nature of the tumour, if you take any work upon the subject, and examine into the symptoms there given of scirrhous mamma, you will find that, in a great number of important points, the symptoms are here absent; yet there is not the slightest doubt that this is a case of scirrhous mamma, and that, I hold, is the value of clinical observation as compared with doctrinal teaching. If a surgeon go and examine a case of this kind with his mind filled with the tabular statement of symptoms, the absence of many of the most important of these symptoms might lead him to believe that it was not a case of scirrhus. But by bringing the patient before you, and making her tell, in her own simple way, all that she knows and all that she could tell you in private, and by examining the tumour simply and regularly before you, and by learning everything about it, we are driven to the conclusion that in practice we must meet with a great variation from the ordinary run of cases as described in books.

What is the nature of this tumour, and what should be done in the circumstances? Now, I do not intend to give you a list of all possible tumours, or of all growths in the mamma or other parts of the body; but I think it is very important to put before you a clinical view of the subject. Tumours of the mamma are of two great classes—the malignant and the non-malignant. Simple or non-malignant tumour consists of the collection into one spot of one of the normal constituents of the body. Thus, confining our attention to the mamma, we may have fatty tumour, fibrous tumour, adenoid tumour; and these are simple, because they consist of the same substances which form normal parts of the body. Malignant tumour, on the other hand, is formed of a collection of substances which are a new growth in the human body; of abnormal substances which do not exist in the body of the living man. That is the essence of the distinction between the two kinds of tumour. If you examine the minute structure of the simple non-malig-

nant tumour, you will find it to consist of a modification, it may be, of one of the normal tissues of the body; if you examine the malignant tumour, you will find it to consist of tissue of which there is no example in the human body.

With regard to the mode of growth, simple tumour extends by increase of bulk, displacing, pushing aside, perhaps causing to be absorbed, the tissues with which it is surrounded. Malignant tumour increases in bulk by incorporating with itself the adjacent tissues, and gradually converting them into itself. Further, simple tumour is for the most part isolated and incapsulated, contained in a membrane which is called its capsule. Real malignant tumour has no absolute defined membrane, but invades all the neighbouring tissue without any well-marked margin. The ordinary name of cancer is well given to malignant tumour, because it gradually draws into its centre all the neighbouring parts, so that in the end it extends without limitation.

Now it is very important for you to mark well a few of these characteristics, because upon them will depend the opinion that you will give with regard to the propriety or impropriety of operating upon a patient. It is perhaps unnecessary to go further just now; but it will complete the clinical view of the case if I state that, while it is true that there are two great classes divided from one another by well-defined marks simple and malignant, there is a debatable ground between the two—a variety of tumours or growths which it is exceedingly difficult, if not impossible, to assign either to the one or to the other; and, in addition, the malignity of the tumour occurs in different degrees of intensity. That form of malignant disease which is called encephaloid, that called scirrhus, and that called colloid, are three varieties in which there is no doubt whatever of the intense malignity—I mean of their inherent abnormality of growth, if I may use the term, and their enormous tendency to return if removed; so much so that, in dealing with tumours of that kind, we are absolutely unable to say that we expect them not to return, though the time of their return is a matter of doubt. But then there is another kind of malignant tumour, which, though properly called cancer, is less malignant than the others, and this less malignity is shown both clinically and microscopically. Epithelioma or epithelial cancer differs from those which I have previously mentioned in being an exaggeration of the epithelial tissue. I beg you here to remember that I am not going into the deep pathology of tumour; because, were we to go a little further than we are doing at present, we would fall into the discussion between the epithelial and fibrous pathologists. There is one class of pathologists who hold that all tumours, especially malignant tumours, arise altogether from an abnormal change taking place in the epithelial tissues. Another set hold that all malignant tumours arise from an alteration of the fibrous structure in the particular part. Epithelial tumour resembles closely the natural epithelium, only it is more complex in its arrangement. In this way, therefore, while in internal structure it has a certain resemblance to the true malignant tumour, it partakes, also, of the character of simple tumour clinically, because it can be removed with success.

But there is a kind of tumour which belongs to the simple or non-malignant fibrous kind, which partakes of malignancy, inasmuch as it returns after removal. Such is the tumour which used to be called recurring fibrous tumour. You will observe that I am adhering to the old nomenclature; and I do so with the view of conveying information to the comparatively junior students. When you enter the pathological class, you will find that tumours are differently classified.

Having, then, stated these elementary views as to the character of tumours, let us now say a word or two with regard to their treatment. The question I am going to discuss is not so much the possibility of treating these tumours medically in the way of palliation, but particularly with regard to surgical removal. I wish, however, to tell you at the outset that, because a person has a well-defined tumour in the mamma, it is not absolutely necessary to excise it. I shall say no-

thing at present with regard to removal by caustics; but it has fallen within my own experience to have seen several most remarkable examples of the disappearance, I might almost use the term cure, of tumour by pressure; and that information is, I think, of great value, because in many cases, from the constitution or the age of the patient, or from the implication of the neighbouring parts, you could not, with any degree of conscientiousness, recommend removal of the tumour; but I could show you ladies in Glasgow at the present day who have had tumours in their mammæ, and who are now absolutely free from the disease by the application of careful and well-directed pressure. You are aware that pressure will cause absorption both of normal and of abnormal tissue; and you are probably aware that, if a person have an aneurism of the aorta, and if the aneurism continue to grow, it not unfrequently happens, through the tumour pressing upon the sternum, that it gradually induces absorption of the bone until it appears underneath the skin, and, if not arrested, it spontaneously bursts, and causes loss of life. We are all aware of the importance of pressure in assisting the absorption of abnormal fluids; as by the use of a splint and bandage in cases of effusion into joints. In the same way, pressure, well directed to the breast, has a remarkable effect in causing the absorption of tumours; and I now am in the habit of ordering the application of a properly prepared apparatus in cases where, either from the situation, or the implication of the neighbouring parts, I consider that the operation of excising the mamma would be unadvisable.

But, next, with regard to operation: what is the difference in the probable result or prognosis between excision of simple tumour and excision of malignant tumour? If we excise simple tumour, we remove the whole disease, and there is no more tendency to its reappearance. We can, therefore, undertake its excision with absolute certainty of success, so far as return of the disease is concerned. We can never, however, promise to perform any operation with absolute freedom from danger, because, in certain states of the constitution, the smallest scratch may end in death. Persons frequently come to the surgeon suffering from a serious disease resulting from very simple causes. We have at present a man in the infirmary with his hand and arm inflamed to such an extent that he is likely to lose them, and all from a scratch at the point of one of his fingers. It does not matter, then, whether the scratch is given by the surgeon or by the patient; it depends upon the state of the constitution whether or not inflammation will ensue. In the excision of simple tumour, then, all that is necessary is that the whole tumour shall be removed—you must not leave a bit of it. But you can do this with absolute certainty; because all that you have to do is to cut through the surrounding tissues, and remove it entire with its capsule. Should it chance to be irregular, and should you leave any part of it, you have simply to take the precaution of dissecting the bit that remains; and, having done this, you may give a certain opinion that there will be no return of the disease. But, with regard to malignant tumour, it is different, inasmuch as it is not isolated or incapsulated, but is of the nature of invading the neighbouring tissues. It is a difficult point to decide how far it extends in the neighbouring tissues; but, taking it for granted that what appears to you to be the limit of the tumour is not the limit, the golden rule is to make your incision clear of the tumour, to cut well beyond it into the sound tissue.

In excising a tumour from the mamma, do not, if possible, leave a single gland-cell—take the whole mamma away. In certain instances, especially in cases of epithelioma, such as may be situated on the back of the hand, on the sole of the foot, or on any part of the limbs, upon the edge of the lip, upon the face, or upon the extremity of the penis, where epithelial tumours are found, in such situations you can with safety cut away a large portion of the sound tissue beyond the disease; and in these circumstances, you may with certainty predict that the cure will be complete. But, in regard to other tumours not epithelial, there is this one

other thing to be said: that, while you can remove a tumour and its surroundings perfectly accurately, the constitutional tendency that has been the cause of the malignancy—of which I have said nothing at present—that tendency still remains; and you can only hope that it will not show itself, and return in some other part of the body. In the case of malignant tumours, all the other parts in the neighbourhood of the mamma are apt to become secondarily implicated.

Most of you are aware, of course, of the absorbents of the mamma. And here I would say to the students who are not yet out of their anatomical studies, that the study of the absorbents in certain regions of the body is very important—as, for instance, the groin, axilla, etc. Now, it not unfrequently happens that a tumour in the mamma irritates the absorbents, that irritation is communicated to the absorbent glands, and they become enlarged. Besides, while the absorbents are naturally adapted for the purpose of carrying away the fluids of the body which are to be used again, in the case of the diseased tissues they take up the diseased substance, and carry it backward to the lymphatic glands, for the purpose of undergoing elaboration. In this way, there is a danger of the lymphatic glands becoming infiltrated with the cancerous matter. It is not because of the proximity, but because of the course of the absorbents from the mamma through the axilla, that the removal of the mammary gland will not cure or destroy the disease; it will be left in the absorbents. Hence, with regard to the return of the disease, it is of absolute importance, so far as the prognosis is concerned, that you should know whether the axillary glands are implicated or not. If they be, you may be certain that the day is not far distant after the operation—it may be weeks, months, or years—but the day will come when the disease will show itself in the axilla or neighbourhood. You may relieve the patient for a long time; but I believe, if the absorbent glands be in any degree affected, it is a question of time.

Such being a general view of the nature of an operation and its results, let us come back to our case. Here is a woman with a tumour of the mamma that presents many of the appearances of scirrhus, yet some of the symptoms are absent. There is, first, the absence of pain. You will find in most of the treatises on the subject that pain is considered diagnostic of scirrhus—shooting pain, tearing across the chest, very frequently shooting down the arm and giving rise to want of rest. When that is present, it is almost always a diagnostic sign of scirrhus. But its absence is not a proof that it is not scirrhus; for here is a patient who has a tumour as manifestly scirrhus as it can possibly be, as you shall see next Wednesday when we cut it out. Secondly, there is often implication of the neighbouring glands, and that is absent in this case. And there is another point in which this tumour differs from most mammary scirrhous tumours; namely, absence of retraction of the nipple. This, which is commonly regarded as one of the symptoms of scirrhus, is simply a mechanical result. In scirrhus of the mamma, the whole substance involved is converted into a firm, hard, rigid structure. The progress of scirrhus is to extend, to draw together what is a soft, irregular, moist substance into a hard rigid substance, the section of which, in a freshly excised tumour, has very much the appearance of a frosted turnip. The skin of the mamma is more or less movable on it; but the nipple is joined to the gland by ducts and fibrous structures, and consequently, when contraction of the scirrhus takes place, it may recede a little from the skin, and yet the skin does not follow it till adhesion actually takes place; but, the nipple being attached to the gland in which the malignant substance is infiltrated, retraction is simply a mechanical result. In this case, the nipple is partially retracted, but not to such a degree as would indicate scirrhus if there were no other symptoms.

What, then, is the characteristic mark which enables me to say that it is scirrhus? The name indicates. Scirrhus is a substance hard, unyielding, slightly

nodular. When these symptoms are present, there is almost no other tumour of the mamma that it can be.

If this, then, be a case of malignant tumour, of undoubted scirrhus, and if it be true that scirrhus, after being removed, has a great tendency to return, either in the former seat of the disease or neighbouring parts, why do we perform the operation? That is one of the most difficult points for the surgeon to make up his mind upon, and it is a very poor subterfuge for him to tell the patient the *pros* and *cons*, and leave her to decide. In the present instance, the patient is so absolutely unable to come to anything like a correct judgment, that the surgeon should be definite in his opinion. There are a great number of operations in which the patients can assist the surgeon; in which they can make up their minds for themselves. In cases where it is not a fatal malady, in cases where it is a mere deformity of appearance, in these and numerous similar cases, the patient can be taken into the surgeon's confidence. But I do not think it is possible for any patient or friend of a patient in a case such as the present to put himself into the position of having proper information with regard to it, and it is, therefore, for the surgeon to make up his mind. In not a few cases of patients who have been brought before me in private for consultation, I have said, "No; I shall not operate." In a notable example, I have said, "This operation ought to be done;" but it is very difficult to convey to you the reasons that should induce the surgeon to operate, or refuse to do so.

But let us take the present case as an example. What are the circumstances which should induce me to perform an operation upon this patient? First, as regards the tumour; and, second as regards the woman.

As regards the tumour, it is perfectly movable upon the subjacent parts; it is quite clearly non-adherent upon these parts; secondly, the skin upon the circumference of the tumour is absolutely healthy; thirdly, the axilla is perfectly unimplicated. These are the three points with regard to the tumour which make it certain that, if operation be properly performed, the tumour and its connections can be removed without leaving a trace of the disease behind it. Now, scirrhus is one of those forms of disease so connected with the constitution, that it is not at all unlikely that, at no distant day perhaps, the disease may reappear in the other mamma, in the axillary gland, or in some other part of the body; but, even supposing I were perfectly certain that within a year the disease were again to show itself, should I not take that into account?

Let us next, therefore, consider the woman. And I think it is a very important thing for students to get into the habit of considering their patients. I am afraid that the tendency both of the surgeon and the students of surgery is to look at the physical condition of the part, forgetting a little the circumstances of the patient. I hope that is not the case with you; but it is important that it should every now and then be brought before you. Here is a woman who has comparatively suddenly become aware that she has cancer in the breast. I did not need to tell her that; she knew well enough, and that was why she came to me. She said, "I have got cancer in the breast." As you saw, she is of a nervous temperament, and she has a very disagreeable and painful feeling with regard to this scirrhus in the mamma. She has the horror of cancer upon her. Unlike many other diseases, cancer creates in the patient who is conscious that he or she has it a feeling of great depression. This patient wonders what will happen. We do not tell her what will happen, but we all know very well. A growth discovered three months ago suddenly puts on activity, which causes it to increase in size very much more than before. Within that time, probably, adhesion to the skin near the nipple has taken place, and that is the only part that is adherent. What will be the history of the case if I do not touch it? The adhesion to the skin will increase; a little red spot will show itself where the adhesion to the skin exists; within a short time, ulceration will take place, creating a loathsome discharge;

the life of the patient will extend to two or three months, during which her whole existenee, till death relieves her, will be most painful. That would probably be the history of the case. Well, if we be able to perform the operation in such a way as to enable her to recover from its effects, and if we be able to eradicate the disease, temporarily even, we will then have it in our power to say to the woman, You are free from cancer; your tumour is away; your disease is removed; it is in the hands of Providence when it may return; in the mean time, you are a healthy woman. Is it not worth while undergoing an operation which is rarely fatal, rarely dangerous, for the sake of being free from the condition I have described, restored for weeks, months, perhaps years, to a state of perfect health? I maintain that excision of the mamma ought to be performed; and for these reasons, which you may extend to others, I intend to operate upon that woman. I hope and believe the operation will be successful, and when the wound is cicatrized, she will leave the hospital perfectly healthy for the time being. To show that this is no chimerical notion, I ask you to remember the operation you saw performed the first operation-day in this hospital, where you saw removed from a woman a large tumour somewhat of the same kind. She is not here now, because, two days ago, I gave her an admission here to the Convalescent Home at Dunoon, where she is at present enjoying herself; whereas, if the operation had not been performed, she would have been lying in bed, suffering from a loathsome discharge from a disease which would result in her death in a very short time; and I think that is a great deal gained.

In connection with this case, I here show you a remarkable specimen of colloid tumour, the second I have seen during my whole experience, which I removed the other day from a patient aged 70, who is now perfectly recovered.

The second patient I now present to you tells us that she is about 40 years of age, unmarried, and that, about three years ago, she got a blow on her right breast. A year after that, she became conscious of a small swelling on the breast, which has gradually enlarged till the present time. The whole mamma is converted into a firm, hard tumour which adheres to the pectoral muscle; the nipple is retracted, the skin nodulated and ulcerated, and the glands of the axilla enlarged and indurated. I need not tell you that, in such a case, no one would for a moment hesitate. To interfere surgically would not only hasten the fatal issue, but would bring opprobrium on surgery.—*Brit. Med. Journ.*, Feb. 26, 1876.

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Clinical Remarks on Cases of Acute Necrosis. By Mr. SAVORY of St. Bartholomew's Hospital.—Among the subjects treated of by modern writers on surgery, necrosis is one that has received less attention than it deserves. Necrosis is of two forms—acute and chronic. By chronic necrosis is understood such an affection of bone as is constantly seen and operated upon with success in the young adult. Its ordinary course is, that from some cause or other a portion of bone perishes. As a result of this an abscess forms, which is either opened by the surgeon or breaks spontaneously. On a probe being passed through the opening, the dead bone is at once detected. A portion of bone having perished, new bone is formed; the dead portion becomes loose, and remains inclosed in a cavity formed by the new bone. The duration of each case depends on the working out of these results.

Acute necrosis presents features quite different from these. It is a disease the true nature of which has only been recognized in recent times. As here applied, the term "necrosis" is an unfortunate one, for it takes into account only the final result, and not the nature of the affection. It would be better to lay it aside, and substitute "ostitis."

Necrosis is commonest in the shafts of the long bones, because there the bone is densest, and consequently there the vessels are most readily strangled when inflammation takes place. Caries is commonest in the cancellous tissue, because there inflammation can run a longer course

without the circulation being so far impeded as to cause death in mass. Dr. Wilks, of Guy's Hospital, years ago published a paper in the *Guy's Hospital Reports*, on "Deep-seated Abscess of the Limbs;" and the cases there mentioned, looked at with the more thorough knowledge of to-day, are evidently cases of acute necrosis, accompanied, as these always are, by deep-seated abscesses.

To say that periostitis is the cause of acute necrosis is only to tell a part of the truth; so, too, it is an error to affirm that osteo-myelitis alone is its cause. Inflammation of bone, accompanied by both periostitis and osteo-myelitis, is its cause.

With regard to the causes of ostitis: The extension of inflammation from surrounding parts is rare, but may occasionally take place. Scrofula, whatever that obscure constitutional condition may be, must be regarded as predisposing to it. Syphilis is said to be a predisposing cause; but this is very doubtful. The early age at which it occurs negatives the existence of acquired syphilis; and I have not seen the hereditary affection in connection with it. Violence is a frequent cause; but the most frequent is exposure to cold and wet, as is exemplified in one of the cases upon which these remarks are founded. It is also very liable to follow where the vital powers of a patient have been much reduced by fever; thus, it sometimes follows scarlet fever, as it did in the second case brought forward.

A typical case has the following course: A delicate child (for it is a disease almost confined to children) is seized with severe pain in the leg or thigh. On examination, we find an undefined swelling, the bone and surrounding parts being fused together. There are the symptoms of local inflammation and severe surgical fever. Rigors are present, there is considerable elevation of temperature, and increased frequency of pulse. In a few days obscure fluctuation becomes appreciable in the swelling, and if now an opening be made a probe can be passed down to dead bone. During these few days the constitutional symptoms increase in severity. The after-progress of the case is marked by profuse suppuration; hectic takes the place of the surgical fever; and the child may die of exhaustion or pyæmia, or may recover with the limb so far damaged that new bone has replaced the old.

The first case is that of a boy, Robert L., aged ten years. Five months ago, while playing, he strained himself. The strain was followed by aching pain and limping. In the first week in October he got wet; a week afterwards there were swelling and pain in the thigh. The whole limb was everted, and shorter than the other by an inch and a half. The swelling went on to the formation of abscess, which was opened on the 11th. The temperature at one time rose as high as 106°.

As a rule, acute necrosis in the child affects the entire shaft of a bone, the epiphyses escaping, because in childhood they are distinct from the shaft. If they do not escape, the case is desperate; the joint is sure to become involved. In the above case it is doubtful whether the head of the bone became affected with necrosis, or whether the dislocation resulted from disease of the hip which had previously existed. The history of the case rather bears out the latter supposition.

The second case is that of a girl, Louisa F., also aged ten years. After an attack of scarlet fever, followed by abscess under the side of the chin, the right knee is described as becoming affected with acute synovitis. This subsided in about three weeks, but some swelling remained on the inner side of the thigh, where also there was doubtful fluctuation. Poultices were ordered, an abscess formed and was opened, and dead bone was detected with the probe. Subsequently erysipelas supervened and spread from the wound upwards. This is usually the direction which the disease takes; but in this case, after spreading upwards for some time, it changed its course and went downwards.

When necrosis has taken place, the sources of new bone in the adult are the periosteum, the living remains of the old bone, and the surrounding soft parts. But for the regeneration of bone in the child one of these is lost, for the periosteum perishes from the fierceness of the inflammation. The specimen shown should be looked upon as one of the most

valuable in the museum, for it shows this point very well. It is the clavicle of a child, which, with its periosteum, has entirely perished from this disease.

The epiphyses are capable of playing a very important part in the production of new bone. In two cases where the entire shaft had perished, I have seen its reproduction brought about by the growth of new bone upwards and downwards from them till it has met in the centre.

A few words may be said respecting the occurrence of pyæmia in these cases. As a cause of this, acute necrosis is second only in frequency to wounds; and I fancy pericarditis accompanies cases of pyæmia resulting from acute necrosis oftener than from other causes.

With regard to treatment, it is best to cut down at once, and deeply, to the bone. By doing this the infiltration of surrounding parts and the destruction of the periosteum are prevented. In practice, amputation is rarely performed to avoid pyæmia. So long as that is only a possible event, it would not be justifiable, but when it threatens it would be right. Generally the indications for amputation depend on the part of the bone affected. So long as the shaft alone is diseased, so long we may hope to do without it; but when the epiphyses become involved, it only remains to choose the most fitting time for its performance.—*Med. Times and Gaz.*, March 4, 1876.

HOSPITAL NOTES AND GLEANINGS.

Treatment of Rheumatic Fever by Salicylic Acid, under the care of Dr. BROADBENT, *at St. Mary's Hospital.*—Few diseases have had brought against them a heavier armament of drugs than has acute rheumatism. It has been stormed by alkalies and salines, attacked by acids, assaulted by perchloride of iron and by quinine, surprised by propylamine and elaylchlorüre, drained by venesection and purgatives, flooded alternately with hot and cold water, alarmed with blisters, blasted with hot air, lulled by opium, and appeased by chloral hydrate. In addition to these, it has been constantly harassed by the raids of lesser foes, such as lemon-juice, citric acid, belladonna, and iodide of potassium. Now another apparently powerful enemy has appeared. Salicylic acid has been shown by Stricker to be able to prevail against some cases of acute rheumatism, and Dr. Broadbent's experience seems to confirm this character. The beneficial action of the drug in the following cases was constant and unequivocal. Whether the reputation of this remedy will prove more durable than that of its rivals remains to be seen. The drug is at least worthy of a careful and complete trial.

For the following notes we are indebted to Mr. Jackson Gawith and Mr. H. Sworder, house-surgeons.

CASE 1. E. H., aged thirty-one, domestic servant, was admitted Feb. 2d, suffering from rheumatic fever. She was first taken ill on Jan. 28th. On admission, she had severe pain in the left ankle, the right knee (which was greatly swollen, tender, and contained fluid), and the right wrist and elbow. The heart's action was frequent, the sounds normal; temperature 103°; pulse 128. Salicylic acid was ordered to be given in doses of seven and a half grains every hour for six hours. —6.30 P. M.: After having taken four powders, the pain in the joints was not quite so bad; perspiration not increased; heart sounds normal; pulse weak, 120; temperature 102.2°. —11.30: Seemed comfortable; had slept soundly for three hours. Tongue furred, but moist; temperature 101.2°; pulse 100.

Feb. 3. Perspired freely during the night. Had not been sick. Pain in legs somewhat increased on movement; tongue clean; bowels opened; temperature 99.8°; pulse 96.

4th. Better; legs not painful, but stiff on movement; temperature 99.2°; pulse 90; heart-sounds normal.

5th. Patient had a very restless night, but the pain in the joints was much less, and there was less stiffness; temperature 98.8°; pulse 84.

6th. The salicylic acid was ordered three times a day. Patient quite free from pain; joints of normal size, not tender or stiff. Heart-sounds normal, appetite improving. Temperature 98.4°; pulse 80.

7th to *14th*. Convalescence satisfactory, and she was discharged on the 14th, feeling quite well and strong.

Case 2. L. W., aged seventeen, a valet, was taken ill on Feb. 19th, remaining in bed next day on account of pain in his legs and swelling in his right knee. On admission on the 23d the symptoms of acute rheumatism were well marked. The legs were drawn up and very painful. Temperature 103°; pulse frequent, artery large, full between beats; a grave soft systolic murmur heard at apex of heart. Fifteen grains of salicylic acid ordered every hour for six hours. The first powder was taken at 6 P. M., the temperature at 5.35 being 102.6°; pulse 120.—8.35: Temperature 102.4°; pulse 114.—10.30: Temperature 100°; pulse 110. By this time he was quite free from pain.

Feb. 24. Patient slept soundly and perspired very freely during the night. There was a little pain again in the right leg; bowels not open; tongue furred. Temperature 100°; pulse 108. At about 4 o'clock in the afternoon the powders were repeated for four doses. At 7 o'clock the temperature was 100.2°; pulse 110. At 10 o'clock the temperature was 99°; pulse 80.

25th. Patient passed a good night. Did not perspire much. Quite free from pain; bowels open. Still a slight murmur heard at apex. On being removed to the convalescent ward, he left the chair in which he was being wheeled, and ran to his bed. Appetite improving. Temperature 98.4°; pulse 84. Convalescence good.

Case 3. E. L, aged twenty-five, servant, had had two previous attacks of rheumatic fever. Ten days before admission she took cold. Her throat became sore, and she took to her bed on February 9th, and on the 13th she was attacked with severe pains in the arms and legs, accompanied by extreme tenderness; the knee-joints also became swollen and red, while the tongue was thickly furred and dry, and the bowels constipated.

On admission, on the 15th, all the above symptoms were well marked. Temperature 101.6°; pulse 104.—At 10 P. M, temperature 102°; pulse 96. A Dover's powder and an alkaline mixture were given, and an alum gargle was used for the throat.

Feb. 16. Patient did not sleep well, but perspired freely during the night; both legs and the left arm (especially at the wrist) painful, tender and swollen; throat not so sore. Temperature 100.7°; pulse 100.—1.45 P. M.: Salicylic acid ordered in twenty-grain doses every hour for six hours, and an alkaline spray to throat.—2.45: Temperature 101.6°; pulse 100.—4.40: Temperature 100°; pulse 92.—6.20: Temperature 100°; pulse 90.—7.40: Temperature 100.2°; pulse 96.—10.30: Patient in very little pain; throat easier since the use of spray. Inclined to sleep.

17th. Patient slept well and perspired freely in the night; pain had left all parts except the wrist, but the limbs still felt stiff. Temperature 100°; pulse 96.

18th. Throat quite well; tongue cleaning; patient stated that she has no pain whatever; had a good night's sleep; bowels not open. Temperature 99.4°; pulse 88.

19th. Patient slept well; no pain or stiffness; less perspiration; appetite improving; urine normal, sp. gr. 1030. Castor oil ordered on account of the confined state of bowels. Temperature 99.2°; pulse 84.

22d. Patient has continued free from pain since the 19th, but the temperature was not quite normal until this morning. Temperature 98.4°; pulse 80.

23d. Patient not quite so well; complained of a severe headache, and also of feeling sick. Bowels constipated. Temperature 99.6°; pulse 100. Citrate of iron and quinine ordered to be given three times a day.

27th. Some improvement till the afternoon of the 26th, when a decided relapse took place, with pain, swelling, and redness of the wrist. Tongue thickly coated and dry. Temperature 101.4°; pulse 98. Salicylic acid was repeated in twenty-grain doses every hour for six hours.

28th. Much better. Pain in wrist quite gone; perspired well after powders. Temperature 99.8°; pulse 90.

March 1. Patient not quite so well again. Complained of some pain in the

left wrist, which appeared somewhat swollen, and was painful to the touch. Temperature 99.8°; pulse 94. Appetite very poor. The salicylic acid was repeated in the evening in the same dose as before, but only for three hours. The patient slept well, and next morning she was quite free from pain. Bowels open; appetite not so good. Temperature 98.4°; pulse 84. Patient continued to improve, and left hospital quite well on the 10th.

Case 4. J. C., aged nineteen, general servant, fell ill about a month before admission, with some pain in the shoulder and right elbow. When admitted on Feb. 28th she was suffering from well-marked symptoms of rheumatic fever. The right arm was painful, and the wrist greatly swollen, red, and very tender. There was also some tenderness in lower extremities. The tongue was dry and furred. Temperature 102.8°; pulse 108; respiration 28. A loud friction-sound, intensified by pressure of the stethoscope, was audible. Six powders of salicylic acid, twenty grains each, ordered to be taken, one every hour. After the first powder the pain became much easier, but the temperature remained the same.—9 P. M.: Temperature 102.8°; pulse 110.—10.30: Temperature 102.4°; pulse 108.—11.45: Temperature 101.8°; pulse 112.

Feb. 29. Had a good night; perspired freely; was in very little pain; appetite improving. Continue broth diet. 8 A. M.: Temperature 99.8°; pulse 96.—8 P. M.: Temperature 100.8°; pulse 104. 10 P. M.: Temperature 101.8°; pulse 108. Powders repeated for three hours.—11 P. M.: Temperature 100.2°; pulse 98.—12.10 A. M.: Temperature 98.6°; pulse 92.

March 1. Patient had slept soundly, and felt better; was in no pain, but there was some stiffness about the joints. Temperature 98.8°; pulse 96.—5 P. M.: A slight return of pain in wrist, so that the powders were repeated for four hours. Temperature 98.8°; pulse 84.

2*d*. Had a good night's rest, and was quite free from pain. There was a soft mitral systolic murmur heard at apex; skin moist; tongue clean; bowels open; appetite improving. Temperature 98.4°; pulse 68.

8*th*. Convalescence went on well, patient feeling stronger daily. Was discharged a few days afterwards, temperature having been normal for over a week.

Remarks by Dr. Broadbent.—The cases reported speak for themselves, but it may be stated that they were all well-marked examples of acute rheumatism, and that two of them were of more than average severity. The results of the treatment of rheumatic fever by salicylic acid in the practice of Stricker, of Berlin, were so remarkable that the earliest opportunity was taken of bringing the drug to the test of experience. The mode of administration recommended by Stricker is that twenty to thirty grains be given every hour for six doses, but at the first trial at St. Mary's only seven grains and a half were given at each of the six hours, simply suspended in water. No bad effects being observed, the dose was increased. It was impossible not to be astonished with the effects, and notwithstanding the many disillusions experience in medicine brings, not a few of which have been furnished by acute rheumatism, I should not do justice to my conviction were I not to say that apparently we have in salicylic acid, as Dr. Maclagan has said in his communication, a remedy for rheumatic fever comparable to quinine as a remedy for ague. According to present experience rheumatic fever when treated by this drug is an affair of two or three days. The disease is common enough, and its usual course sufficiently well known, so that no long time will be required to establish some definite conclusion, and to bring out any possible injurious effects. The only complaint hitherto made of the acid is that it is hot and irritating to the throat; given in milk, vomiting has been produced.

Careful examination of the effects on the pulse, temperature, urine, etc., will no doubt yield important information. Mr. Sworder, who has watched the cases very closely, states that the temperature invariably rises for a short time after the administration of the first dose, but the observations recorded in the careful notes taken at short intervals by him and Mr. Gawith show a gradual fall both of temperature and pulse rate. No sphygmo-

graphic observations were made. Relief from pain was always quickly obtained, and, as a rule, the patients slept well, no opiate being required; as a rule, again, there was very free perspiration, but this of course is common in acute rheumatism. —*Lancet*, April 8, 1876.

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Idiopathic Anæmia.—L. E., aged twenty-one, a clerk, was admitted into Guy's Hospital under the care of Dr. HABERSHON, on January 28. Since childhood he has had very fair health, though always rather thin and pale, and unable to take vigorous exercise. For some years has been liable to occasional slight attacks of epistaxis. His two sisters have suffered at the same age as his from symptoms said to be somewhat like the present illness. Patient states that the present illness commenced in the first week of last December, and that it appeared to have had a sudden starting-point from a pain in his left hip while out at a party. Since then he has been laid up at home. During the last six weeks he has suffered from aching and shifting pains in his thighs and back, which, however, were never very acute. He has had three slight attacks of epistaxis during the same period. He has also been troubled two or three times lately with a suffocative feeling in his chest. His appetite has not failed him as yet. He has never noticed any blood in his motions or urine; the motions have not been unusually dark.

State on Admission.—Patient is five feet ten inches in height, well developed and proportioned, though slightly built; thin; extremely pale, without being of either a greenish or earthen hue. Is hardly able to stand from extreme weakness; lies on his back; no cough or dyspnœa; appetite good; no vomiting; bowels regular, feces natural. Hepatic dulness increased. Lung region resonant; breath-sounds natural; cardiac impulse diffused; cardiac area not increased; sounds clear; no bruit; pulse 138, small and compressible, regular. There is a pulsation all over the epigastric angle, most marked to the left of the middle line. A loud systolic bruit is heard all over the epigastrium with the lightest application of the stethoscope, but it is not heard with the unaided ear. Heart-sounds are heard behind, and especially well over the lower left intercostal spaces, where a diffused impulse is observed, which is continuous round the side of the chest with that in the epigastrium. Loud *bruit de diable* on each side of neck. Urine loaded with lithates, but otherwise normal. Temperature 100.8°.

January 29. Temperature 99°; pulse 110; respiration 18. Has saturated two pocket-handkerchiefs with blood, which seems very poor in colouring matter.

30*th.* Temperature 99.5°; pulse 120; respirations 20. Fainted when he got up to have his bed made. Evening: Temperature 100.4°; pulse 116; respirations 24.

February 3. Patient says that he feels much better to-day. Was ordered the following mixture: ℞. Ferri et ammon. citr. gr. x, spt. ammon. aromat. ℥xx, spt. ætheris chlor. ℥x, ex aquâ ʒss, ter dies.

5*th.* Morning: Temperature 102.4°; pulse 130. He says he feels very well this morning; he did not feel faint on standing up. Evening: Temperature 100.6°; pulse 134.

6*th.* Morning: Temperature 98.6°; pulse 126; respirations 22. More epistaxis.

8*th.* Reports himself as feeling very ill to-day. There is much retching and sickness.

10*th.* Temperature 98.4°. Has another attack of sickness. Systolic bruit audible all over the cardiac region, loudest on right side of sternum.

11*th.* A dense London fog. Patient is much worse to-day; was very sick in the night; takes very little nourishment; is very thirsty. He says he feels giddy and drowsy; he answers questions with hesitation and difficulty. Tongue brown and quite dry. Pulsation in epigastrium is much more forcible. 2 P. M.: Is quite unconscious, tossing himself about. Temperature 97.5°; respirations 40; pulse scarcely perceptible. 3 P. M.: About six ounces of blood drawn from the vein of a friend defibrinated, and kept warm by means of hot water outside the vessel con-

taining it, was transfused into patient's right basilic vein. The only effect of the operation was to make him breathe a little deeper, but he sank half an hour afterwards.

A post-mortem examination was made by Dr. Hilton Fagge. No glandular enlargement was found. The liver was healthy, and weighed seventy ounces. The spleen was firm, and weighed ten ounces. There was fatty degeneration of the musculi papillares of the left ventricle of the heart, and in left side of septum ventriculorum. There were ecchymoses on the visceral pericardium, especially on the left side; ecchymosis also on endocardium of left ventricle; the valves were healthy. The kidneys contained in their cortex small white bodies, mostly like spots, near the surface, but one was as large as a pea and vascular. Examined microscopically, it was found that fibrous tissue predominated in these little tumours. The brain and lungs were healthy.—*Med. Times and Gaz.*, March 4, 1876.

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Acute Necrosis of the Tibia, in which the Diseased Shaft of the Bone was removed by Resection, leaving the Periosteum; Reproduction of Shaft.—Two instructive cases of this are reported in the *Lancet* (March 11th), which were treated by Prof. SPENCE in the wards of the Edinburgh Royal Infirmary, and which show the remarkable reparative power of the periosteum. We quote one of them:—

R. H., æt. 10, was admitted on the 27th March, 1875, suffering from acute necrosis of right tibia. Three weeks before admission the patient had been kicked by a horse on his right shin. The leg subsequently became swollen and painful, and two abscesses formed in front of the tibia. These were opened a week before admission, but as profuse hemorrhage occurred from the periosteal vessels, he was sent into the infirmary.

On admission the tibia was seen white and bare through the incision which had been made to evacuate the abscess. From these openings there was a copious discharge of pus. The boy was very weak and anæmic from loss of blood. His pulse was weak and rapid. Operative interference was considered unadvisable at the time, owing to the exhausted state of the patient. He was accordingly put upon a tonic course for some days, and a stimulating lotion was applied to the incisions.

On the 5th of April, the patient being put under the influence of chloroform, and Esmarch's apparatus applied, Professor Spence connected the two previous incisions, thus exposing the whole length of the shaft of the bone, which was bare in its entire extent. The periosteum all round the bone was then separated by means of a periosteum scraper, and the entire shaft of the bone was removed, after resection above and below with the chain saw. Scarcely any blood was lost.

The wound was stuffed with lint soaked in carbolized oil. A posterior splint was applied, and the limb slung.

Next day short lateral splints were applied in addition, so as to give shape to the limb. The stuffing was removed, and the wound was dressed with a many-tailed bandage of lint soaked in a solution of boracic acid.

The patient went on well, and by the beginning of June the new bone thrown out from the periosteum felt hard and firm, and had the same shape as the normal tibia. The wound had by that time cicatrized over in the centre. Patient was ordered ivory-dust in form of jelly. The upper and lower parts of the wound healed slowly, and small spicules of bone were occasionally removed from the epiphyses.

The patient was discharged on August 8th. The bone was then very strong, and the tibial ridge only deficient at the upper part, where the periosteum had ulcerated previous to admission. A posterior splint of poroplastic felt was directed to be worn for some months so as to obviate any risk of the new bone yielding under the weight of the body.

Prof. Spence, in remarking on these cases, observes that they are especially instructive as showing the advantages of resection in certain cases of acute necrosis. I find this method sometimes spoken of as if shortening the period of

treatment were its object. It could scarcely be advocated on that ground. Its real advantages are—(1st) The early removal of a diseased texture which is injuriously affecting the health and keeping up irritative fever. (2d) By removal of the diseased shaft to diminish the risk of neighbouring joints becoming affected, thus necessitating amputation under most unfavourable conditions. (3d) Obviating the risk of repeated hemorrhages from ulceration of large periosteal vessels. Whilst the result of these and other similar cases shows that the removal of the diseased bone is speedily followed by relief of the constitutional disturbance, and that we can trust to reproduction of bone from the periosteum left.

The two cases were testing cases for the operation, as both patients were extremely debilitated; and in the case of the girl, the sloughing of the integument and periosteum over the front of the tibia, and the subsequent necrosis of the fibula, made me very doubtful what might be the result.

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Conservative Surgery.—An extremely rare, if not altogether a new, operation was performed at the Middlesex Hospital on Wednesday, March 8th, by Mr. MORRIS.

A woman about thirty-three years of age had for fourteen months been suffering from a myeloid tumour of quite the lower end of the radius, which gradually expanded the bone until only a thin shell of it remained. It extended upwards along the forearm for about 4 inches, and was slightly connected with the periosteum of the ulna. As the patient refused to undergo any operation by which her hand would be removed, and as all the soft structures appeared to pass over the tumour, Mr. Morris determined to remove the lower two-thirds of the radius, and two or three inches of the lower end of the ulna. This was done successfully without dividing any trunk nerve or artery, except the anterior interosseous, at their lower end: and the only tendons cut were those of the supinator longus and the pronator radii teres at their points of insertion into the radius. The guide to reaching the radius, and thus to lifting aside the soft structures from the tumour, was the radial nerve. This was found as it passes on to the back of the forearm between the supinator longus and the long radial extensor of the wrist, and then those muscles were separated up as high as the lower border of the supinator brevis; the nerve being kept, with the extensor muscles, on the back of the forearm, and the long supinator being raised with the muscles on the flexor aspect.

A portion of the lower end of the ulna was removed for a further reason than because of its connection with the tumour, as it is expected that there will be less deflection of the hand to the radial side than must necessarily have been the case had the ulna been left untouched. The patient has done uninterruptedly well, so far, since the operation.

The application of a ligature to the anterior interosseous artery could be effected without much difficulty, Mr. Morris thinks, by employing the same incision and guide as were used in this case.—*Lancet*, March 18, 1876.

MEDICAL NEWS.

ORIGINAL ARTICLES.

How to Preserve and Stain for Microscopical use some Elements of the Urine and other Fluids. By CHRISTOPHER JOHNSTON, M.D., of Baltimore, Md.

After urine containing organic elements has stood undisturbed in a vial sufficiently long for a deposit to accumulate, with a pipette draw off all supernatant fluid. To the sedimentary layer add half its volume of a quarter of one per cent. of alcoholic solution of magenta or Nicholson's blue. Shake once or twice, cork tightly, and label.

If the specimen be not absolutely fresh, add to the above one-third of its bulk of alcohol.

Many fluids, such as the contents of ovarian and other cysts, or fluids associated with cancerous disease, may be preserved in the same way.

In concentrated urine the constituents of deposits are relatively numerous; and

small organic granules, epithelium, and recent cases, are distinctly stained, they are very conspicuous and easily found. Old hyaline casts take colour indifferently and slowly, and appear of a very pale hue. In Bright's disease new attacks yield easily stainable casts, which, even if not mixed with blood and other signs of acuteness, will, by the aniline, be readily distinguishable from casts the result of an ancient condition.

With a dip tube place a drop of the sediment, or fluid if there be no sediment, upon a slide, adjust the cover, and while the particles are vividly coloured the field appears to be white.

Urine and other fluids so prepared may be set aside for future use, studied at leisure, or sent unchanged to a distance.

BALTIMORE, April 6, 1876.

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Case of nearly Fatal Result from the Accumulation in the Stomach of Carbonic Acid Gas after Swallowing Citric Acid and Bicarbonate of Potassa. By GEO. W. CHRISTIAN, M.D., of Weimer, Texas.

A young man of vigorous constitution had taken a mercurial purge for relief from a bilious attack. On the morning of the second day after, he took a glass prepared fresh with acid. citric. ʒiv, pot. bicarbonat. ʒvss, aqua ℥viij. After swallowing this draught, he complained of a fulness and uneasy sensation about the chest.

When I saw him, not more than thirty minutes afterwards, he was complaining of great pain about the stomach, and that "he could not get his breath," and could not swallow. He was making violent efforts at inspiration without being able to accomplish it. His face was livid, eyes glaring, pulse feeble. In less than one minute after I got to him, he became comatose, his limbs rigid and cold, and pulseless at the wrist.

I had forced down him a large quantity of ipecac just before he had grown entirely insensible, and aided the vomiting by tickling his throat with the finger.

I had the upper and lower extremities vigorously rubbed with capsicum and mustard. Kept up the tickling in the throat until free vomiting occurred, which took place in from three to five minutes. After free emesis the spasm relaxed, respiration was free and easy, and consciousness returned in two or three minutes more. After vomiting, I gave lime-water to neutralize any acid that might remain. The recovery was perfect and rapid; in an hour he was up attending to his business.

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Acute Rheumatism treated with Salicylic Acid. By WM. F. WHYTE, M.D., of Watertown, Wis.

Saw Lizzie P—— in the evening of March 12th. She had been sick three days. Skin hot, tongue coated, pulse 115, temperature 102½°. Left wrist and both ankles swollen, slightly reddened, and could be moved only with great pain. Complains also of pain in her knees. Prescribed alkalies, and Dover's powder to secure rest. On the evening of March 13th, general condition as before; pulse 120, temperature 104°. Both wrists and knees swollen, and complains of pain in the hip-joints. Salicylic acid was prescribed, gr. vijss, every hour when awake. March 14th, evening, found her comparatively free from pain, and swelling in the affected joints considerably diminished. Pulse 110, temperature 102½°. Saw the patient again on the morning of the 16th. She had walked across the room, was entirely free from pain, and the swelling in the affected joints had disappeared. Pulse 80, temperature 99°. Duration of treatment with salicylic acid sixty hours. Amount taken about 3 drachms.

DOMESTIC INTELLIGENCE.

Supra-pubic Lithotomy.—Dr. GUIDO BELL relates (*The American Practitioner*, March, 1876) the following case of this:—

T. N., a delicate boy, three years and a half old, had, when three years old, a vesical calculus, the size of a pea, removed; a month after, again had symptoms of a stone in the bladder.

On the twenty-fourth of October, 1875, I performed supra-pubic lithotomy, the patient being completely under the influence of chloroform. The stone, which was the size of a large bean, and having

abundant crystals on its surface, was removed with the index finger; the incision in the bladder was closed by a single silk suture, silk sutures were used for the abdominal incision, and an ointment, containing carbolic acid and morphia, applied externally to the wound.

In two hours some bloody urine was passed by the urethra, and the patient slept moderately well the first night succeeding the operation. On the twenty-fifth, considerable fever and nervousness; on the twenty-sixth, the superficial sutures were removed, and the wound emitted a decidedly gangrenous odour; and on the twenty-ninth, urine escaped freely through the now opened wound.

On November first, the gaping edges of the wound were brought together with adhesive plaster, and soon after the urine resumed its natural channel. At the end of a month a small fistula existed; but it healed spontaneously by December 25th, and the patient is now quite well.

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Conception within forty hours after Abortion.—A remarkable case of this is related by Dr. Jas. R. Sparkman, *Charleston Med. Journ. and Review*, April, 1876. The miscarriage was not followed by any hemorrhage, and the patient, feeling quite well, submitted twice to her husband's advances, who was about to leave home for some time about forty hours after her abortion. She was delivered two hundred and seventy-eight days after this congress, of a fully developed infant weighing ten pounds.

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International Medical Congress, Philadelphia, 1876.—The following additional subject for discussion in the Section of Otology has been announced:—

4th Question. What is the best mode of determining the hearing of school-children, and how should partially deaf children be instructed—in mixed classes with those who hear well, or in separate classes where due allowance will be made for their defective hearing? Reporter, Clarence J. Blake, M.D., Instructor in Otology in Harvard University.

Charles H. Burnett, M.D., Surgeon to Philadelphia Infirmary for Diseases of the Ear, has been selected as Reporter of the 2d Question, *vice* Dr. Blake.

All the reporters, at the close of their opening remarks, will sum up the views expressed therein in a series of conclusions subject to modification, which, at the end of the debate, will be voted upon separately and then reported to the Congress in general meeting for confirmation.

The *Lancet* (April 15, 1876), in calling attention to the programme of the Congress, says, "The questions that will be submitted are well calculated to be provocative of discussion from their debatable character, or the novel and fresh or interesting points involved in them." . . . And concludes by expressing the hope that many Britons will "be present at what promises to be a very important and most interesting Medical Congress."

The following distinguished foreigners have already notified the Commission of their intention of attending the Congress: Prof. Stromeyer, of Hanover; Prof. Jaccoud, of Paris; Prof. Lebert, of Breslau; Prof. Lazarewitch, of Kharkoff, Russia; Mr. Lauder Brunton, of London; and Mr. Jolliffe Tufnell, of Dublin.

The Iowa State Medical Society has elected the following delegates to the Congress: Drs. J. C. Hughes, of Keokuk; J. W. Smith, of Charles City; A. G. Field, of Des Moines; S. B. Thrall, of Ottumwa; Wm. Watson, of Dubuque; E. W. Clark, of Grinnell; P. J. Farnsworth, of Clinton; D. S. Fairchild, of Ames; and J. M. Emmert, of Atlantic.

The Medico-Chirurgical Society of Montreal has appointed the following delegates: Drs. Godfrey, Howard, Fenwick, Hingston, Trenholme, Ross, and Bell.

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International Congress of Ophthalmology.—This Congress will be formally opened at noon on Tuesday, the twelfth day of September, 1876, at Chickering Hall, Fifth Avenue, New York. The committee charged with the preliminary arrangements consists of Drs. C. R. Agnew, H. D. Noyes, and D. B. St. John Roosa.

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Kentucky State Medical Society.—This society held its annual meeting at Hopkinsville, on the 4th of April. The fol-

lowing officers were elected for the ensuing year: President, R. W. Gaines, of Hopkinsville; Vice Presidents, Dr. C. H. Todd, of Owensboro, and L. S. McMurtry, of Danville; Recording Secretary, Dr. J. H. Letcher, of Henderson.

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Library of the College of Physicians of Philadelphia.—We are gratified in being able to state that this valuable library continues steadily to increase. The number of volumes added during the past year was *one thousand and seventy-nine*, of which number *four hundred and forty-six* were contributed to the Lewis Library by its munificent founder. The whole number of volumes in the library now amounts to considerably over *nineteen thousand*.

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University of Pennsylvania —The Board of Trustees of this Institution have for some time had under consideration the subject of improving the system of medical education in the school under their control.

On the 7th of December, 1875, a resolution was passed, "That a special Committee of eight Trustees be appointed to consider in what respects the organization and curriculum of studies may be with advantage modified in the interests of the Medical Department and of Medical Education, and, if practicable, to report a plan for reorganising said Department."

Since the date of its appointment, this Committee, which included the medical gentlemen of the Board, namely, Drs. Geo. B. Wood, J. Rodman Paul, and S. Weir Mitchell, has been actively engaged in obtaining all the information possible to enable it to reach a definite conclusion as to the course to be recommended for adoption.

The Committee in their Report, which was presented on the 28th of March, state: "A careful review of the subject leads the Committee to the opinion that the Medical Department should ultimately be reorganized upon the following basis:—

"The time of instruction should be extended to three years; the diploma being granted after examination at the end of the third year.

"The annual course of instruction should be extended.

"The instruction should be graded substantially as follows:—

"*In the First Year.*—Anatomy; with constant dissection; physiology; inorganic chemistry; materia medica; pathology; histology.

"*In the Second Year.*—Theory and practice of medicine; theory and practice of surgery; theory and practice of obstetrics; therapeutics; organic chemistry; physiology; anatomy; all the clinical branches.

"*In the Third Year.*—The same studies as in the second year, but more advanced, and with the clinical branches and laboratory work predominating.

"There should be weekly examinations by the several professors on the lectures in their respective branches, and examinations at the end of each course on the studies pursued during the course, for the purpose of testing the qualifications of the student for admission to the next course.

"Finally, when the proper time comes, examination for matriculation should be required, in order that the class may be somewhat more evenly prepared to profit by the instruction of the first year.

"The fees of the students under such a system should be paid to the Treasurer of the University, the expenses of the school should be borne by the Board of Trustees, and the professors should be paid fixed salaries.

"A graded course offers more advantages to the student than the course as at present arranged, because it introduces the beginner to the elementary branches of the science first, and, as his habits of thought improve and his acquaintance with the subject increases, the more difficult and complicated parts are presented to him. This method of teaching is so universally adopted in other branches of education that it seems hardly necessary to attempt to bring forward any arguments in its favour."

"The Committee recognizes perfectly the fact that any change of system which might temporarily or permanently diminish the size of the classes, by weeding out those students who are incompetent to enter or to take an advanced course, and

those who are unable or unwilling to spend the additional time and money which it would require, would have to be supported by an endowment or a guarantee fund, and it is therefore proposed that at the present moment only such changes be made as will not affect the relations of the students to the school, but will serve to make the internal organization of the department more complete."

"The Committee considers that the Medical Faculty and the Hospital Staff should be in some way united, so as to secure that harmony of action which is necessary to entire success.

"All the chairs of the Hospital Staff, however, not being of equal importance in the scheme of instruction, the Committee recommends that the following professors of the Hospital Staff be added to the Medical Faculty:—

"The Clinical Professor of Surgery.

"The Clinical Professor of Medicine.

"The Clinical Professor of Diseases of Women and Children, and

"The Professor of Pathological Anatomy and Histology, with the title of Professor of General Pathology and Morbid Anatomy."

From correspondence with the Medical Faculty the Committee learned that the establishment of the foregoing professorships was desirable.

The Report was laid over for consideration.

The two accompanying resolutions were adopted by the Board as recommended by the Committee.

"*Resolved*, There be added to the present Faculty of Medicine of the University of Pennsylvania the following Professorships of the Hospital Staff as they are at present filled.

"The Professorship of Clinical Surgery (Dr. Neill).

"The Professorship of Clinical Medicine (Dr. Pepper).

"The Clinical Professorship of the Diseases of Women and Children (Dr. Goodell).

"And the Professorship of Pathological Anatomy and Histology, with the change of title to that of Professorship of General Pathology and Morbid Anatomy (Dr. Tyson).

"*Whereas*, Efforts are now being made to raise an endowment fund for the Medical Department,

"*Resolved*, That out of the income of such endowment fund the incumbents of these chairs shall be compensated in such manner as may be provided for by the Board of Trustees; and that in the event of there being no such fund, the said chairs shall, until it be raised, have no pecuniary claim on the Board."

We congratulate the University and the advocates of a higher medical education on this first step in the improvement of the curriculum of the oldest medical school in the United States.

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Medical Graduates in 1876 (continued from p. 57).

Missouri Medical College	67
St. Louis Medical College	46
Indiana Medical College	32
Medical College of Virginia	17
University of California	13
Medical College of the Pacific	11
Miami Medical College	50
Columbian University (Washington, D. C.)	12
Georgetown University	13
Medical College of the State of South Carolina	27

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Wills Ophthalmic Hospital.—This Hospital, the proper and official title of which is "Wills Hospital for the Relief of the Indigent Blind and Lame," has now been diffusing its benefits for upwards of forty years. From the report for the year 1875 we are pleased to learn that during that period its capacity for usefulness has been enlarged by the erection of two pavilion wards with a capacity of forty beds, thus doubling the capacity of the Hospital. During the past year 8922 have been treated, of which 338 were house-patients, and 3584 were out-patients. 809 operations were performed, of which 81 were for cataract, and 55 for strabismus.

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Philadelphia Infirmary for the Diseases of the Ear.—From the second report of this institution we learn that during the year ending Dec. 1, 1875, 350 patients availed themselves of this charity. Dr.

Charles H. Burnett is the Surgeon in Charge. The Infirmary is located at present at No. 43 South 17th St. It is open daily from 12 to 1 o'clock.

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German Eye, Ear and Throat Infirmary.—This Institution, which was reorganized in March last, is situated at the S. E. corner of Fifth and Green Sts. The Surgeons in Charge are F. D. Castle, M.D., and C. Seiler, M.D. It is open daily (Sundays excepted) from 3 to 4 P. M., for the gratuitous treatment of indigent persons.

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Dispensary for Skin Diseases.—From the fifth report of this Institution, now on our table, we learn that 371 cases were treated during the past year. Dr. Louis A. Duhring is the Physician in Charge, and Dr. Arthur Van Hartingen the Assistant Physician. This dispensary is open daily, Sundays excepted, at 11 A. M., at 216 South 11th St.

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Convalescent Hospital. — The elegant Hotel at West Point, well-known as Cozzens', has been purchased by a lady of New York, and presented to the Society of the N. Y. Hospital, to be used as a convalescent hospital.

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Micro-Photographs in Histology.—J. H. Coates & Co., of Philadelphia, propose to publish photographs in Histology, normal and pathological, by Carl Seiler, M.D., in conjunction with J. Gibbons Hunt, M.D., and Jos. G. Richardson, M.D.

This publication is intended to replace the microscope, as far as is possible, for those physicians who have neither opportunity nor leisure to make observations with the instrument for themselves; and also to furnish microscopists, for comparison, correct representations of typical specimens in the domain of normal and pathological histology.

As the pictures are obtained directly from the microscopic objects by means of photography, and printed from the negative by a reliable mechanical process, they have the great advantage of being faithful copies of the pictures formed by the lens, and there is nothing produced that is not actually visible in the instrument, thus avoiding the diagramatic character and the subjective colouring which is so frequently found in drawings made by means of the camera lucida. In fact, the illustrations used in the lecture-room, and found in books, are idealized so much as rarely to give an exact impression of the specimen as it really exists.

The photographs are to be carefully prepared by Dr. Seiler, and will be accompanied by a few pages of text, describing each plate, under the supervision of Drs. Hunt and Richardson.

The work will be issued in monthly numbers, each containing at least four plates with descriptive letter-press. Subscription price six dollars per annum.

—

Corrigendum.—We beg to call the attention of our readers to the fact that in Dr. Gross's Century of Surgery in America (*American Journal of the Medical Sciences*, April, 1876) the name of Dr. J. M. Carnochan was incorrectly placed on the list of recently deceased surgeons of eminence. The author of the article was led into that mistake by a short sketch of Dr. Carnochan which appeared in the new edition of *Johnson's New Universal Cyclopædia*, where it is stated that Dr. C. died in 1872. We take pleasure in informing our readers that Dr. Carnochan is still living and is engaged in the active pursuit of his profession.

—

The Stromeyer Jubilee.—The friends of Professor Stromeyer, as a token of their appreciation of the valuable services which he has rendered to scientific surgery, met at Hanover early last month, to celebrate the fiftieth anniversary of his entrance into the medical profession. A short time before this event, a letter was received from two of his London friends, Dr. W. J. Little and Mr. W. Mac Cormac, asking the surgeons of Philadelphia to unite with their European brethren in raising funds, in the sum of ten dollars each, towards a fund for a marble bust of the great surgeon, to be presented to him on the occasion. In compliance with the wishes thus expressed, ten gentlemen promptly sent their names, with their

contributions, to the agent in charge of the matter. From a letter just received from W. Mac Cormac, Esq., we learn that a copy of the bust in plaster of Paris will be sent for one of the public institutions in this city.

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In Memoriam.—At a meeting of the Pathological Society of Philadelphia, held on Thursday evening, April 13, 1876, the death of Dr. Jno. S. Parry having been announced by the Secretary, it was unanimously—

Resolved, That in the untimely death of our late Vice-President, Dr. Jno. S. Parry, we have to deplore the loss of a valued officer of the Society, and of a colleague whose zealous devotion to the promotion of pathological science and whose sterling personal qualities have secured the lasting admiration and regard of all his fellow members.

That the Secretary be requested to transmit a copy of this resolution to the family of Dr. Parry, and to have it published in the medical journals of this city.

—

Obituary Record.—Died, of Bright's disease, at New Orleans, Feb. 24, Frank Hawthorn, M.D., Professor of Diseases of Women and Children in the New Orleans School of Medicine.

—— at Sacramento, Cal., Feb. 13, of typhoid pneumonia, aged 68 years, Thos. M. Logan, M.D., Prof. of Hygiene in the Medical Department of the University of California; Secretary of the State Board of Health, etc. etc.

FOREIGN INTELLIGENCE.

Treatment of Acute Rheumatism by Salicin.—Dr. T. Madagan terminates an interesting report (*Lancet*, March 4 and 11, 1876) of seven cases of acute rheumatism successfully treated with salicin with the following conclusions:—

"1. We have in salicin a valuable remedy in the treatment of acute rheumatism.

"2. The more acute the case, the more marked the benefit produced.

"3. In acute cases, its beneficial action is generally apparent within twenty-four, always within forty-eight, hours of its administration in sufficient dose.

"4. Given thus at the commencement of the attack, it seems sometimes to arrest the course of the malady as effectively as quinine cures an ague, or ipecacuanha a dysentery.

"5. The relief of pain is always one of the earliest effects produced.

"6. In acute cases, relief of pain and a fall of temperature generally occur simultaneously.

"7. In subacute cases, the pain is sometimes decidedly relieved before the temperature begins to fall; this is especially the case when, as is frequently observed in those of nervous temperament, the pain is proportionally greater than the abnormal rise of temperature.

"8. In chronic rheumatism, salicin sometimes does good where other remedies fail; but it also sometimes fails where others do good. . . . .

"The dose of salicin is from ten to thirty grains every two, three, or four hours, according to the severity of the case. Fifteen grains every three hours is a medium dose for an acute case. It is very possible that less might suffice; for I have not tried to find the minimum dose. It is very certain that a much larger dose may be given without producing discomfort.

"Salicin is not soluble to any useful extent; it is best administered as a powder mixed with a little cold water. It is a very pleasant bitter. I have never found the least inconvenience following its use."

—

Hyoscyamin in Chorea.—Dr. Oulmont has been very successful in five cases of chorea, treated by him with hyoscyamin in his wards of the Hôtel Dieu. In one case the patient was two months pregnant. Various drugs had failed, and notably bromide of potassium in doses of three drachms daily. Hyoscyamin was given in gradually increasing doses of from two to eight milligrammes daily. Amelioration was soon evident, and the case speedily got well.—*Lancet*, March 18, 1876.

The Ophthalmoscope in Injuries of the Head.—M. PANAS (*Gaz. Hebdom.*, Feb. 26), in a paper read at the Académie de Médecine, on the condition of the eye as observed by the ophthalmoscope after injuries of the brain, founded upon seven cases, five of which are accompanied by autopsies, comes to the following conclusions with respect to the stationary condition of the pupil: 1. The stasis of the pupil is often observed as a consequence of various traumatic lesions of the encephalon. 2. It is not always accompanied by visual disturbances; so that the fundus of the eye should always be examined with the ophthalmoscope, whether these exist or not. 3. According to the autopsies, this stasis seems to depend upon the infiltration of blood or serum into the sheath of the optic nerve, and not upon the cerebral lesion itself. 4. This stasis does not seem to indicate the particular variety or the gravity of the injury of the brain. 5. All that this stasis allows us to affirm is that it indicates the presence of a liquid effused into the membranes.—*Med. Times and Gaz.*, March 4, 1876.

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Asthma.—Dr. J. W. ANDERSON records (*Glasgow Med. Journ.*, April, 1876) a peculiar case of asthma in which inspiration was accomplished with absolute freedom; the difficulty was solely in expiration.

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Deaths from Chloroform.—A Liverpool dentist adds another name to the long list of cases of needless deaths. The chloroform was administered for the extraction of teeth, and a pliant jury in bringing in a verdict of "death from misadventure" absolved the administrator from all blame.—(See *Brit. Med. Journ.*, April 1, 1876.)

The same journal for the succeeding week reports another case at Leicester. Less than a drachm and a half of chloroform was administered altogether, and the heart's action was discovered before the operation to be perfectly healthy and with no murmur.

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A New Plan for detecting Bile-pigment in the Urine.—For the clinical demonstration of the presence of bile-pigment in urine, Dr. ROSENBACH, of Jena (*Centralblatt Med. Wiss.*, No. 1, 1876), recommends the following methods as an improvement on those ordinarily employed: The urine is filtered through ordinary white filter-paper, by which means the latter is rendered of an intense yellow or brown tint. If a drop of slightly fuming concentrated nitric acid is now allowed to fall on the inner side of this prepared paper—that is to say, on the side which was turned towards the fluid—the spot which it touches becomes yellow, then yellowish-red, and at the edge of a beautiful violet tint; further out there forms an intensely blue ring, which passes over almost immediately into an emerald-green colour. It is best to use the paper in the moist state, without allowing it to dry after filtration. The play of colours produced by the acid is beautifully shown by allowing a drop to trickle down the inner surface of the filter, the reaction becoming more intense the nearer the acid gets to the apex of the cone. If the filter be allowed to dry and put aside for a few days, it is only necessary to moisten it with distilled water, and then to use a drop of acid, to obtain a characteristic play of colours. The reaction does not occur in highly coloured urines which are not icteric.—*Med. Times and Gaz.*, March 25, 1876.

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The Mosaic Sanitary Code.—Last week, Dr. B. W. RICHARDSON delivered a lecture on "The Mosaic Sanitary Code and its Influence on the Vitality of the Jewish Race" to Jewish working men and their families, in the Jews' Infant School, Commercial Street, E.; Sir B. Ellis occupied the chair. The lecturer remarked that, many years ago, while engaged in an investigation into the cause and nature of the cholera epidemic, a statement was made that no Jew had died from cholera. The statement, though not strictly correct, was yet so near the truth that it struck his attention and that of others who were engaged in sanitary work. This, he said, led him to the study of the subject of the vitality of the Jews, and the result of his research had shown that, both on the Continent and in this country,

Jews possessed a higher vitality than did the general community by whom they were surrounded. Tracing the causes for this greater longevity, the lecturer said he could not attach too much importance to the sanitary laws that obtained amongst the Jews, instancing those in regard to diet, cleanliness, and abstinence from strong drink. In fact, the Decalogue from beginning to end was one sanitary lesson, teaching them to subdue the passions which tormented the brain and distressed the spirit.

—

Severe Accident caused by a Telegraph Wire.—A remarkable case of this, showing the danger which may arise from telegraph wires stretched on poles, is recorded in the *Med. Times and Gaz.* of March 13, last.

A severe storm in London blew down telegraph wires which stretched across the roadway leading to an omnibus yard. "Almost immediately afterwards an unfortunate hostler was driving an omnibus into the yard, and, being probably prevented by the heavy snow-storm from seeing the wire, he was caught by it under the chin, as it were in a loop, and, being unable to stop the horses, his throat was cut clean across as if by a knife, all the soft structures immediately above the hyoid bone being divided to the vertebræ. The wound then took an upward direction behind the ramus of the inferior maxillary bone on each side, and terminated at the base of the skull, the resistance of the bone being, it is believed, sufficiently great to break the wire. Death must have been instantaneous, as the large vessels in the neck were completely divided. Sir John Hawkshaw states in the *Times* that galvanized wire does not last more than a dozen years, and in all probability the first intimation of decay will be the falling of the wires upon passers-by; and the weight of the wires falling from such heights as those at which they are now so frequently suspended will generally be sufficient to kill or maim those upon whom they fall.

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Measurement of Light.—Mr. Crookes's most able experimental research on the conversion of light into motion, on which he lectured last Friday at the Royal Institution, has opened up a new field of physical investigation, and has an immediate application to medical science, which we hasten to point out. The influence of light upon the functions of life and health is very great; and it has long been a source of regret that there does not exist any accurate means of registering the amount of light falling upon any given spot. This defect will now be supplied by Mr. Crookes's photometric radiometer, which will register accurately all the variations in amount of light, and record every passing cloud. Such an instrument will, we apprehend, shortly become an indispensable addition to every set of meteorological apparatus, and will be highly useful to the physician and the climatologist. So quickly do scientific discoveries now-a-days fructify with result. Mr. Crookes was led to his present conclusions by the observation of an "anomaly of experiment," which he has investigated with a most admirable exactness and sagacity, and by the aid of a series of researches of singular beauty, and which will be memorable in the history of physical science.—*Brit. Med. Journ.*, Feb. 19, 1876.

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Portrait of Vesalius.—We find it stated (*Le Progres Médical*, Feb. 19, 1876) that a portrait of Vesalius painted in 1540 by Jean de Calcar has been discovered in the Louvre, Paris, where it has remained for upwards of 170 years unrecognized.

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Ovation to Prof. Robin.—The day after the election of Prof. Robin as senator, the large amphitheatre was crowded to the ceiling, and when he appeared to deliver his lecture he was received with "phrenetic" applause, which lasted several minutes, accompanied with the cries, "Vive Robin!" "Vive la République!" and most of all, "A bas Dupanloup!" When silence was obtained, the Professor exclaimed, amidst thunders of applause, "It is not me you applaud, it is the Republic!" At renewed cries of "A bas Dupanloup!" he added, "Attack no one, gentlemen, for that is the best mode of

showing that we are really strong." He then went on to speak of the nervous system to a very diminished auditory. When he quitted the theatre, the manifestation was renewed outside; and as torches could not be obtained, the students (500 or 600 in number), amidst loud shouts, contented themselves with escorting the Professor towards his home. Finding their course, however, barred in one of the streets by a large squadron of police, they were obliged to disperse.—*Union Méd.*, Feb. 5. [Three provincial medical men have also been elected senators, and Dr. Testelin was one of the life-senators elected by the National Assembly.]—*Med. Times and Gaz.*, Feb. 12.

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International Medical Congress, Geneva, 1877.—The International Medical Congress of 1877, of which Prof. CARL VOGT is to be President, will open on the 9th of September at Geneva, and will last a week. French is to be the official language. Dr. Prevost, of Geneva, is the General Secretary.

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Royal College of Physicians.—Dr. RISDON BENNETT has been elected President of this College in place of Sir George Burrowes, who declined a re-election.

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OBITUARY RECORD.—Died, March 15th, at his residence, at Bitterne, Professor E. A. PARKES, of the Netley Military Medical School. Professor Parkes' eminent services in the Crimean hospitals during the Russian war attracted the attention of the Government, and, at their solicitation, he resigned his office at University College Hospital, and his eminent position as a physician of the first rank in civil life, to assist in the organization of the great medical school and hospital at Netley for training young medical officers on their entry into the military service. Lord Herbert placed justly great reliance on his judgment, and all successive administrations have known how to appreciate his large scientific knowledge of all that belongs to military hygiene and the preservation of the health of troops in the barrack, the camp, and the field. His great work on *Hygiene*, and his valuable annual reports, have long been scientific standards. As a member of the Commission on Equipments, and as an adviser of the government on all matters of clothing, dietary, ventilation, and water-supply, he has contributed more, perhaps, than any other man in our day to that notable diminution in military mortality which is so great a source of congratulation to economists and to the nation at large. His wisdom, moderation, and gentleness of character were such as to secure to him the confidence and the affection of all with whom he came into contact. His loss is great to the whole country and to every branch of the profession. It will be most deeply felt by the host of friends and pupils to whom his unvarying sweetness of character and almost womanly kindness had endeared him, while his great attainments and pure spirit of self-sacrifice commanded their deep respect. —*Brit. Med. Journ.*, March 18, 1876.

—— at Ixelles (Belgium), March 17, 1876, aged 76 years, JEAN FRANCOIS VLEMINCKX, Member of the Chamber of Representatives, Inspector of Health of the Army, President of the Royal Academy of Medicine of Belgium, Vice-President of the Superior Council of Public Health, President of the late International Medical Congress at Brussels, etc. etc. His contributions to medical science were numerous and on various subjects.

—— at Brighton, March 5th, in the 63d year of his age, Sir JOHN CORDY BURROWS, M.D., President elect of the British Medical Association.

—— at London, March 29th, HENRY LETHEBY, M.D., the well-known chemist, toxicologist, and sanitarian.

—— at London, April 15th, of acute pleuro-pneumonia, Mr. CAMPBELL DE MORGAN, F.R.S., honoured and respected by all who knew him. He was notable for great independence of character, a chivalric sense of professional honour, and intellectual energy.

—— in Birmingham, aged 75, WILLIAM SANDS COX, F.R.S., the founder of the Birmingham School of Medicine, a skilful surgeon, an active philanthropist, and an earnest promotor of medical education.

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This little book has already done good service, and we are glad to find it has passed to a third edition. Its present form is no mere reprint. A cursory glance will suffice to show that the author has spared neither trouble nor expense to bring the work up to the requirements of the day. Old wood-cuts are in many instances replaced by new, besides which a large number of illustrations entirely new, are added. The text also has been changed in many places and considerably augmented, and has been brought, on the whole, well up to the results of recent research.—*The Dublin Journal of Medical Science*, Jan. 1876.

The author of this valuable little work is to be congratulated on the demand for it that has already called for a third edition. It affords gratifying testimony to its value and popularity as a text-book. It possesses further all those qualities which render such a work popular among students. It is written in clear and concise language, it is confined almost entirely to statements of facts, theoretical views having for the most part been kept out of sight, and it is above all fully and exceedingly well illustrated.—*London Lancet*, Aug. 2, 1875.

Altogether we are in a position to endorse the encomiums we formerly passed on the volume as being the best we could put in the hands of the student.—*London Medical Times and Gazette*, Oct. 25, 1873.

WINCKEL ON CHILDBED—Just Ready.

THE PATHOLOGY AND TREATMENT OF CHILDBED. A Treatise for Physicians and Students. By Dr. F. Winckel, Professor and Director to the Gynæcological Clinic in the University of Rostock. From the Second German Edition, with Notes by the Author. Translated by James Read Chadwick, M.D., Clinical Lecturer on Diseases of Women, Harvard University. In one handsome octavo volume of 485 pages: cloth, $4 00.

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Introduction.—Normal Childbed—General Etiology of the Diseases of Childbed.—Section I. *Puerperal Affections of the Genital Organs.* Chapter I. Genital Lesions of Lying-in Women. II. Displacements of the Vagina and Uterus. III. Hemorrhages from the Genital Organs of Women in Childbed. IV. Inflammation of the Genital Organs. V. Thrombosis of the Veins. VI. Nomenclature and Varieties of the Infectious Puerperal Diseases. VII. Etiology of the so-called Puerperal Fever. Appendix. Section II. *Puerperal Diseases of the Breast.* Chapter I. Diseases of the Nipples. II. Diseases of the Integument of the Breast and of the Submammary Connective Tissue; Paramastitis. III. Inflammation of the Mammary Gland itself. IV. Irregularity in the Secretion of Milk. Appendix. Section III *Affections of other Organs occurring in Connection with Childbed.* Chapter I. Affections of the Urethra and Bladder. II. Affections of the Articular Ligaments of the Pelvis. III. Neuralgia and Paralysis of the Lower Extremities. IV. Puerperal Eclampsia. V. Mental Affections of Lying-in Women. VI. Skin Diseases of Lying-in Women.

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